

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015598

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 203

FILED MAY 1 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>1 1/2 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ski View Manor</u>		d. STREET ADDRESS (If outside, give location) <u>4245 Woodland</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>ANNA MYRTLE McREYNOLDS</u>			4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>62</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/1897</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Hospital Grand Pass, Mo</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John W. Jalle</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Argood</u>	
14. NAME OF HUSBAND OR WIFE <u>Arthur L. McReynolds</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>23 Calvin L. Jalle 4242 Woodland</u>	

17. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Paralysis right arm. General debility and senility.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Independence, Mo.</u>	

21. I attended the deceased from <u>Oct 1960</u> to <u>4-22-62</u> and last saw her alive on <u>4-21-62</u>	
Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>E. H. Blackman</u>	(Degree or title)	22b. ADDRESS <u>10901 Winner Road Independence, Mo.</u>	22c. DATE SIGNED <u>4-24-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/25/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Mo</u>
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24. FUNERAL DIRECTOR <u>C.H. Blackman & Son K.C. Mo</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>4-25-62</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300
Rev. 4/59

17005

23649

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10901 Winner 128

MAY 2 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Hubert B. Baird

Licensed Embalmer No.

4888

P. O. Address

DC 24 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.